NHS Shetland/Shetland Islands Council

Falls

Policy for Reducing and Managing Inpatient Falls

Date: February 2012
Version Number: Three

Author: Falls Strategy Group, Co-ordinated by Jo Robinson

Date of Approval: February 2012
Review Date: February 2014

If you would like this document in an alternative language or format, please contact Corporate Services at 01595 743000 (via Switch)
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<td>Firm up monitoring arrangements</td>
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<td>Referral arrangements, assessments checked and verified</td>
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<tr>
<td>04/11</td>
<td>Initial outline circulated</td>
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<tr>
<td>10/11</td>
<td>DNMAHPs added in referral information, training, roles and responsibilities, KPIs and communication plan</td>
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<tr>
<td>11/11</td>
<td>HoD of Physiotherapy added in the assessment tools and guidance for STRATIFY</td>
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<tr>
<td>11/11</td>
<td>HoD of Dietetics reviewed the documentation to ensure that it corresponds with bone health and nutritional guidelines</td>
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<tr>
<td>11/11</td>
<td>HoD of Physiotherapy defined the risk assessment levels for referral into the Physiotherapy service using the STRATIFY tool</td>
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Policy for Reducing and Managing Inpatient Falls

1. **Introduction**

1.1. In February 2007, the Health Department of the Scottish Executive issued their Delivery Framework for Adult Rehabilitation and Prevention of Falls in Older People. Health Boards were asked to take the lead in developing with all relevant partners a combined falls prevention and bone health strategy by the end of 2007-8. We have continued to develop our falls strategy over this time.

NHS Shetland and the Community Health and Care Partnership (CHCP) has developed a local strategy which sets out our key objectives in regard to the promotion of bones health and preventative strategies to reduce the number of falls occurring across hospital, community and social care settings. Operational policies have been put in place to ensure that these preventative initiatives and interventions are taken forward.

This policy is one in a series of four – the policies are:

A& E Falls Management
In-Patient Falls Management
Managing Falls in the Community
Managing Falls in the Care Home Setting

1.2. For patients in hospital settings, Health Boards were asked to ensure that:

- Protocols are in place to ensure falls risk minimisation
- A systematic process is in place for the management and prevention of falls
- Appropriate falls awareness education, support and guidance is provided to all staff regardless of their role in the hospital, where patients may be at risk of falling
- Accurate recording and reporting of incidents, including falls, are reported through the accident reporting procedure
- Design issues are considered in new builds and refurbishments

2. **Definition of a Fall**

A fall is commonly defined as “an event which results in the person coming to rest inadvertently on the ground or other level”¹ and may be further defined as “other than as a consequence of the following; sustaining a violent blow, loss of consciousness, sudden onset of paralysis, or an epileptic seizure”²
3. **National Information**
   - 30% of all people aged over 65 living in the community fall each year. \(^3\)
   - 42% of all people aged over 75 fall each year. \(^4\)
   - Over 50% of hospital admissions are due to accidental injury (no reference cited)

   In 2001 the combined NHS and Social Care costs for a single hip fracture in the UK were estimated to be £20,000. Recent evidence suggests that each hip fracture costs the NHS alone £12,137, over £7,000 more than the figure used in earlier estimates. \(^5\)

4. **Local information:**
   
   In the period 01/01/08 to 30/06/08:
   - 77 patients seen in A&E following a fall
   - 30 admissions to hospital from A&E following a fall
   - 60 inpatient falls in GBH and Montfield Hospitals

   We are actively undertaking a stock take of incident cases which will inform future service delivery.

5. **Aim of this Policy**
   
   The aim of this policy is to:
   
   1. Reduce the total number of falls occurring in the hospital by providing an evidence-based, patient-centred approach to reducing the risks of harm and promoting patient safety
   2. Heighten awareness and knowledge of staff, patients and carers on the prevention and causes of slips, trips and falls
   3. Provide guidance for the actions to be taken when a patient has fallen.

6. **Scope**
   
   This policy applies to all staff working within the in-patient settings within the Gilbert Bain Hospital.

7. **Falls and Risk**
7.1. Falls management requires an approach that increases patient safety in hospital by identifying patients at risk and implementing interventions that reduce patient falls, including consideration and assessment of environmental risk factors. It is, however, recognised that patient safety should be balanced with the promotion of patient recovery and independence, with the aim of discharging patients home safely.

7.2. Management of patients at risk of falls should be tailored to individual risks and needs. It is essential to identify patients considered to be at risk of falling as part of the admission procedure.

7.3. **Patients known to be at increased risk of falls:**

- Over 65 years of age
- History of falls
- Mobility impairment
- Patient in need of frequent toileting especially at night
- Patient agitated or confused
- Sensory deficits e.g. vision, hearing, sensation
- Neurological changes
- Medication known to affect balance/cognition or poly-pharmacy

7.4. **Medications that Increase Risk of Falls**

Older patients are more sensitive to the effects of medication and evidence suggests that there is a significantly increased risk of falling in those patients that receive the following medications:

- Psychotropic medication (neuroleptics, benzodiazepines and antidepressants)
- Anti-arrhythmic medications
- Digoxin
- Diuretics
- Opioids

7.5. **Patients, who have fallen should have their medications reviewed and, if appropriate, altered or stopped (in light of their risk of future falls)**
Particular attention should be given to:

- Poly-pharmacy
- Psychotropic medications

7.6. **Inpatient Assessment for Falls**

Evidence and best practice guidance\(^6,7\) for reducing the risk of falling advocates the following approach, with regular review and monitoring:

- Implementation of standard falls prevention strategies for all in-patients.
- Identification of patients at high risk of falls followed by the implementation of a Falls Care Plan.
- Identification of common potentially reversible risk factors on admission and implementation of a management/care plan appropriate to the risk factor identified.
- A post-falls assessment for all patients who fall on the ward.

Further guidance is detailed below for the above four stages.

7.7. **Implementation of standard falls prevention strategies for all in-patients**

There are many strategies for reducing patient falls. The standard measures for falls prevention identified below (Appendix 1) are considered to be simple, easy to administer and have been proven to be clinically effective:

<table>
<thead>
<tr>
<th>Measures</th>
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<tbody>
<tr>
<td>Ensure that night lights are on during hours of darkness.</td>
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<tr>
<td>Ensure bed brakes are locked and the bed is in a low position (except when giving care).</td>
</tr>
<tr>
<td>Ensure that the chair is at appropriate height for patient</td>
</tr>
<tr>
<td>Ensure that bed rails are used when patient is nursed on a trolley or during transportation on a bed or trolley</td>
</tr>
<tr>
<td>Ensure bed rails are used when patient anaesthetised/sedated/during post-op recovery</td>
</tr>
<tr>
<td>If patient is considered to be at risk of falling from the bed implement an ‘at risk’ of falling from bed care plan. See NHS Shetland Restraint Policy.</td>
</tr>
<tr>
<td>Ensure the nurse call system is working, within sight, easy reach and patient is able to use it.</td>
</tr>
<tr>
<td>Ensure correct spectacles are within easy reach and are clean.</td>
</tr>
<tr>
<td>Ensure correct use of hearing aid.</td>
</tr>
<tr>
<td>Ensure personal items are within easy reach.</td>
</tr>
</tbody>
</table>
7.8. **Identification of patients at high risk of falls, which includes those patients who are at risk of falling from the bed, followed by the implementation of a Falls Care Plan.**

- A falls risk assessment will be completed for each patient within twelve hours of admission followed by the implementation of the management plan (Appendix 3 – STRATIFY Falls Risk Assessment Tool). This should assess the risk of falling from the bed, chair, commode or toilet. The risk assessment will be reviewed weekly or on any relevant change to the patient’s condition.
- A Fracture risk assessment should be carried out using FRAX - the World Health Organisation’s Fracture Risk Assessment tool. This can be found at [http://www.shef.ac.uk/FRAX/tool.jsp](http://www.shef.ac.uk/FRAX/tool.jsp).
- All patients identified as being at ‘high risk’ of falls must have a Falls Care Plan implemented (Appendix 4).
- A patient information leaflet ‘Reducing Patient Falls’ (Appendix 5) should be given to all patients identified as being at high risk of falling.
- All patients identified as being at risk of falling from the bed should be appropriately assessed. The ‘Adult Restraint Policy – Alternatives and Considerations Including Bed Rails’ includes assessment tools to guide decision making in relation to the use of bed rails, including as part of a risk management plan to reduce the likelihood of falls. The Restraint Policy can be found at the following link: [http://www.shb.scot.nhs.uk/documents/pphandbook/index.asp](http://www.shb.scot.nhs.uk/documents/pphandbook/index.asp)
- A patient information leaflet ‘Safe use of bedrails in hospital’ should be given to all patients who are identified as at risk of falling from the bed if bedrails are applied.

7.9. **The following additional preventative measures must be considered for patients identified at ‘high’ risk of falls**

- Patient is clearly identified as being at high risk of falls in the nursing notes through carrying out the STRATIFY Falls risk assessment.
- Assess the patient’s position in ward for ease of observation
• Assess the need for increased supervision or one to one supervision where possible.

• Consider the use of ‘Lock ‘n’ Glide’ mats to prevent slips from chairs

• Toileting needs identified and accommodated day and night.

• Ensure referral to Physiotherapy has been made and Occupational Therapy if required.

• Review medication for potential effects of sedatives, diuretics and alcohol.

**Safe Use of Bedrails**

• For patients who have been assessed as being at risk of falling from the bed consider their suitability for having bed rails fitted – see NHS Shetland Bed Rail (Restraint) Policy. [http://www.shb.scot.nhs.uk/documents/ pphandbook/index.asp](http://www.shb.scot.nhs.uk/documents/pphandbook/index.asp)

**High/Low Beds**

• The use of ‘high/low’ beds should be considered for those patients that have fallen from the bed and are at risk of further falls from the bed. If no high/low beds are available, a request should be made to the Senior Nurse to obtain one.

7.10. **Assisted Technology Solutions**

Consider assisted technology solutions e.g. chair alarms. There are several items of equipment available to support patients and carers in their own homes which may also be suitable for use in hospital settings, either for short term use in the clinical area or for continued use in the patient’s home after discharge from hospital. Any equipment should be trialled on an individual basis for suitability. Within a clinical setting, assistive technology must not compromise the individual’s dignity or independence and should not impact on other patient’s comfort e.g. repeated alarm noises. For further information and advice about assistive technology contact the Occupational Therapy Service can be accessed via the following link: [http://www.shetland.gov.uk/socialwork-health/OccupationalTherapy.asp](http://www.shetland.gov.uk/socialwork-health/OccupationalTherapy.asp)

7.11. **Identification of common potentially reversible risk factors on admission and implementation of a management/care plan appropriate to the risk factor identified.**
Based on information ascertained through the falls risk assessment, care plans will be implemented as appropriate (Appendix 4).

All relevant information regarding the patient’s falls risk assessment including referrals, interventions, strategies, education and communication with other healthcare professionals must be recorded in patient care plans/records, and be explained verbally during ward hand over/reports, multidisciplinary meetings. All team members must be aware of the patient’s risk status, and the interventions and strategies implemented.

7.12 Comfort rounding and falls prevention

As part of the falls prevention plan, patients that are at risk of a fall will receive regular ‘comfort rounds’. This means that nursing staff will be required to check three areas of patient care each hour from 8:00am to 6:00pm, and every two hours from 6.00pm to 8.00am.

The three areas are as follows:

- **Positioning**
  
  Make sure the patient is comfortable and assess the risk of pressure ulcers

- **Personal needs**
  
  Schedule patient trips to the bathroom to avoid unsafe conditions.

- **Pain**
  
  Ask patients to describe their pain level on a scale of zero to 10 and offer medication/ treatment, if necessary

Recent studies show that this intervention reduces pressure sore development, reduces falls risk, reduce the need for patients to use the call buzzer and improves patient satisfaction.

Comfort rounding will be monitored as part of the patient safety measures at ward level.

7.13 Post-falls assessment for all patients who fall on the ward

**Nursing Assessment Following a Fall in Hospital:**

The following should be completed in all cases by a senior nurse:

**Immediately:**

1. Check the patient for any obvious injury.
2. Ensure the patient is made safe and comfortable

3. Observations that may be undertaken include:
   - Temperature
   - Pulse
   - Blood Pressure
   - Respiration rate
   - Oxygen saturation
   - Blood sugar if patient diabetic
   - If possible postural blood pressure
   - Glasgow Coma Score (GCS).

4. Document findings in patient’s records.

5. Alert the Ward Doctor of the requirement for a Post Falls Medical Assessment. The Doctor should be fully informed of the findings of the nurse’s clinical assessment following the fall. The Doctor must be made aware that a Post Fall Medical Assessment should be recorded in the Medical notes.

6. All equipment/ mobility aids should be checked for damage before re-use.

**Within 24 hours:**

1. Review Falls Risk Screening Tool and implement relevant care plans

2. Check postural blood pressure (if appropriate)

3. Consider referral to Occupational Therapy/Physiotherapy (if appropriate)

**7.14 Post Fall Medical Assessment**

The list below is the minimum required. Further assessment should be undertaken depending on the results of the minimum assessment.

1. Examine the patient for any obvious injury

2. Document baseline observations

3. Assess cognitive state and behaviour and record Glasgow Coma Scale if evidence of head injury

4. Take a falls history and witness account which should include:
5. Symptoms preceding fall and/or after fall for example weakness, light headedness, vertigo, seizure, loss of consciousness, pain, nausea

6. Position: fall from bed/Chair, from standing/from walking, unwitnessed, in toilet?

7. Detailed examination

8. Neurological examination (has the patient had a stroke?) including gait if ambulant

9. Examine the drug chart for causative drugs

10. Review recent blood results

11. Expected/unexpected fall?

12. Investigate according to findings.


14. If in pain provide appropriate analgesia

15. Document all in patient’s records

7.15 Head Injury Pro Forma

Head Injury is defined as any trauma to the head other than superficial injuries to the face.

7.16 Emergency Assessment:

1. Stabilise airway, breathing and circulation before attending to other injuries

2. Nurse assessment: Glasgow Coma Score (GCS). The patient must be woken up for this if asleep. Also assess limb movements, temperature, pulse, blood pressure, oxygen saturation, respiratory rate, pupil size and activity

3. Call Doctor for medical assessment

8. **Incident Reports**

All inpatient falls must be reported in accordance with the NHS Shetland Incident Reporting, Investigation and Management Policy 2010 via the DATIX system.

Staff should discuss the actions and learning points that have arisen from any incidents at team meetings and/or governance meetings.

Data describing the number of falls and associated information about lessons learnt will be discussed in the following clinical governance for a:

- The Clinical Governance Co-ordinating Group (CGCG)
The Falls Strategy Group (FSG)

The Quality and Safety Group (QSG)

This is to ensure that there is an opportunity to share improvement ideas and spread good practice as well as evaluate the current performance against falls CQIs.

9. **Patient Information/Education**

All patients and/or relatives and carers will be kept fully informed as to progress and effectiveness of any interventions and strategies implemented.

It is important to ensure that patient information is provided to maintain and promote patient safety in relation to falls prevention. Nurses must ensure that appropriate written advice is given to patients with a risk of falls and that this is documented in the health record.

The following leaflets are available from the Health Improvement Resource Officer in Brevik House:

- Reducing Patient Falls
- Postural Hypotension (feeling dizzy and faint when you stand up) – leaflet no.
- Safe use of bedrails in hospital (refer to NHS Shetland Adult Restraint Policy including use of bedrails)
- Staying Steady; Improving Your Strength and Balance
- Your Safety – Preventing Accidents in Your Home
- Healthy Bones

10. **Documentation**

The record keeping standards guidelines (as set out in the NHS Shetland record keeping audit) must be adhered to. Only assessments, which have been approved by the Falls Strategy Group and Area Nursing & Midwifery Council (ANMAC) and Area Advisory Committee for Allied Health Professionals (AACAHP) will be used to ensure that there is consensus for adoption and that the assessments are derived from an appropriate evidence base.

11. **Environmental Risk Assessment**

There are a number of NHS Shetland initiatives, which ensure that the patient environment is safe. These include a programme of Health and Safety
Inspection visits which are undertaken on an annual basis and more frequently in high-risk areas. The Patient Safety Leadership walkthroughs are also an opportunity to identify key clinical and/or environmental factors where corrective action can be taken to reduce harm to patients such as avoidable falls.

Heads of Department (HoDs) are responsible for ensuring that appropriate actions are taken following H&S Inspection visits where environmental hazards are identified and ensure that the relevant support services are contacted to complete any remedial works or repairs that need to be carried out and timescales for completion as well as the need for any additional resources.

Any serious risks must be reported to the Estates department as an urgent repair. Bearing in mind that repairs may involve the hire of external contractors, materials to be ordered and have Healthcare Acquired Infection implications, the risk should be managed appropriately until a repair can be arranged.

The H&S policy set can be found at the following link: [http://www.shb.scot.nhs.uk/documents/pphandbook/documents/HealthAndSafety.pdf](http://www.shb.scot.nhs.uk/documents/pphandbook/documents/HealthAndSafety.pdf)

**12. Training for Staff**

The Board will ensure that all staff who are required to complete a falls risk assessment receive appropriate training to:
- Undertake a risk assessment
- Design an appropriate care plan
- Signpost patients to information about falls prevention
- Make referrals to other services and/or teams for further assessment

This will be delivered through a programme of cascade training.

**13. Audit/Monitoring**

There are a number of ways in which the policy implementation will be reviewed:
- An annual audit of the KPIs associated with the Inpatient Falls Policy
- Monthly review of incident cases of falls at ward level, using data from DATIX;
- Monthly review of adverse events using the Global Trigger Tool (GTT) or revised local tool, to identify cases where the patient had a fall whilst in hospital (in any setting);
- Monthly review of CQIs for falls management (where applicable including patients identified via A&E);
- Quarterly review of all incident cases of falls at the CGCG, QSG or FSG.
Element | Criterion
--- | ---
**Assessment:** Pt aged 65yrs or over, or have a history of falls, have a falls risk assessment documented, within 24hrs of admission using a recognised risk assessment tool as agreed by your organisation
There is documented evidence that the risk assessment using the recognised tool is supported by clinical judgement and decision making
Evidence of repeat assessments

**Prevention:** Documented evidence within care plan of interventions to minimise falls risk
Documented evidence that falls info has been shared with the patient and relevant others

**Management:** All falls are reported in accordance with the organisations normal clinical incident reporting mechanism
In the event of a fall, evidence that the cause of the fall has been documented within healthcare records and action taken as appropriate
Following a fall there is documented evidence within the plan of care that the patient has been reassessed

Exclusion: Patient is under 65 with no history of falls, Patient is admitted less than 24 hours, Patient has not fallen.

### 14 Roles & Responsibilities

**Director of Nursing, Midwifery & AHPs** – is the executive lead for this policy area and is responsible for ensuring that appropriate governance systems are in place to support falls prevention across the Board.

**Senior Managers** – (in general) are responsible for ensuring that all professions adhere to the policy and that there are appropriate resources in place to implement the key aims of the policy.

**Senior Nurses** – (e.g. Assistant Directors) are responsible for ensuring that the policy is monitored and that any associated governance issues are highlighted through an appropriate route (e.g. Clinical Services Management Team) and corrective actions taken (e.g.)

**Senior Charge Nurses & AHP HoDs** – are responsible for ensuring that the clinical environments are safe (and regular risk assessments are undertaken);

- All of their staff are trained in falls risk assessments and management to an appropriate level for the services that they provide (e.g. nurses will undertake initial assessments and AHPs more specialised assessment and management);
- That staff put in place appropriate care plans for patients with falls risk;
- That falls incidents are reviewed on a regular basis at team meetings and governance meetings.
15 Communication Plan

This policy will be cascaded to staff via HoDs and made available in electronic format on the Internet and Intranet.

The Clinical Governance Committee is responsible for ensuring that the policy has been developed in accordance with the Framework on Document Development and is reviewed according to the schedule set.


16 Key Performance Indicators

<table>
<thead>
<tr>
<th>Item</th>
<th>Target</th>
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<tbody>
<tr>
<td>All staff will be trained</td>
<td>50% of staff trained</td>
<td></td>
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<tr>
<td>Action</td>
<td>Completion Date</td>
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<tr>
<td>to undertake falls risk assessments</td>
<td>by March 2012</td>
<td></td>
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<tr>
<td>All staff will be trained to complete falls care plans</td>
<td>50% of staff trained by March 2012</td>
<td></td>
</tr>
<tr>
<td>All risk actions will be completed following the H&amp;S review</td>
<td>75% by March 2012</td>
<td></td>
</tr>
<tr>
<td>All patients who have high risk factors will have a risk assessment</td>
<td>75% by March 2012</td>
<td></td>
</tr>
<tr>
<td>All patients with high risk factors will be referred to the OT department</td>
<td>75% by March 2012</td>
<td></td>
</tr>
<tr>
<td>Put in place systems to accurately record a baseline for falls in hospital</td>
<td>100% by September 2012</td>
<td></td>
</tr>
<tr>
<td>Falls incidents will be discussed at all team meetings</td>
<td>100% by March 2012</td>
<td></td>
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<tr>
<td>There will be a reduction in the baseline of patients presenting with falls risk who do not already have a risk assessment in place</td>
<td>Reduction from the baseline of 10%</td>
<td></td>
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Endnotes
1 College of Occupational Therapists Falls Management, Lamb SE, Jorstad-Stein EC, Hauer K and Becker C (2005)


5 Torgeson D. Inglesias C and reid DM. The effective management of osteoporosis. In The economics of fracture prevention, edited by Vralow DH, Francis RM and Miles A 2001, p111-121


# Appendix 1 Standard Falls Prevention Strategies for All Patients

<table>
<thead>
<tr>
<th>Section</th>
<th>Precautions</th>
</tr>
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<tbody>
<tr>
<td>Lighting</td>
<td>Ensure night lights are on during hours of darkness</td>
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<tr>
<td>Chair</td>
<td>Ensure that chair is at appropriate height for patient</td>
</tr>
<tr>
<td>Call system</td>
<td>Ensure nurse call system is working, within sight and easy reach, and that the patient is able to use</td>
</tr>
<tr>
<td>Vision</td>
<td>Ensure correct spectacles are within easy reach and are clean</td>
</tr>
<tr>
<td>Hearing</td>
<td>Ensure correct use of hearing aid</td>
</tr>
<tr>
<td>Personal items</td>
<td>Ensure these are within easy reach</td>
</tr>
<tr>
<td>Hazards</td>
<td>Ensure tripping/slipping hazards are eliminated</td>
</tr>
<tr>
<td>Footwear</td>
<td>Ensure any footwear is in good condition, non-slip, low heeled and well fitting</td>
</tr>
<tr>
<td>Walking aids</td>
<td>Ensure correct mobility aid is used – labelled with patients name, and is in good condition (including ferrules) and where appropriate, within easy reach</td>
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</table>
Appendix 2 Reducing Patient Falls – Patient Information

You have been assessed as being at risk of falling.

People recovering from illness often go through a period of increased risk of falling as they regain mobility. Inevitably, this may result in some accidental falls.

Preventing these falls has been extensively researched but there is no evidence that any particular interventions will necessarily be successful.

However, during your stay in hospital everything practical will be done to reduce the risk.

Every effort will be made to provide a hazard free environment and safe equipment.

Please pay particular attention to the following factors. They may help to prevent you falling whilst in hospital.

- Please wear firm fitting, flat shoes or slippers during your stay.
- Pay particular attention to long or very loose nightwear. Wear shorter night-clothes/dressing gown if possible.
- Make sure to use your normal walking aid when mobilising.
- Please use your call bell if you require assistance during the day and at night-time. If you are unable to use the call bell, please talk to a member of staff.
- Wear your normal glasses. Make sure that they are clean or ask a member of staff to help you if you are unable to clean them yourself.
- If you have a hearing aid, please wear it. If this is difficult a member of staff will help you.
- If you or your relatives would like further information please talk to any member of staff.
POSTURAL HYPOTENSION

Patient Information

What is Postural (Orthostatic) Hypotension?

This is when your blood pressure falls very quickly when you change your position e.g. stand up suddenly. This can make you feel dizzy and lose your balance.

What other symptoms may I get?

- Fainting or light-headedness
- General weakness and fatigue
- Blurred vision
- Nausea (with or without vomiting)
- Passing more urine than usual
- Increased sweating
- More prone to falls
- Pain across the back of shoulders and neck

It can develop after:

- Prolonged bed rest
- Prolonged standing
- Large high-fat meals
- Sudden changes in body temperature
- Drinking alcohol
- Not eating or drinking regularly

It is more likely to occur with:

- Dehydration
- Increased age
- Lack of regular exercise
- Varicose veins
- Anaemia
- Some medication
What Medication can Contribute to Postural Hypotension?

- Water tablets
- Heart medication e.g. ace inhibitors, nitrates, calcium channel blockers
- Medication for mood e.g. anti-depressants and anti-convulsants
- Medications for Parkinson’s Disease.
- Any concerns about your medication please contact your GP or practice nurse.

What you can do to help prevent Postural Hypotension

DO

- Increase your fluid intake to more than 2 litres (3½ pints) a day – preferably water, squash or juice (unless instructed otherwise).
- Eat salty snacks such as crisps, nuts and soup.
- Drink caffeinated drinks such as tea or coffee in the morning and after meals.
- Eat several small meals instead of large meals.
- Eat high-fibre food to avoid constipation.
- Elevate bed head or use extra pillows.
- Exercise regularly e.g. swimming, walking.
- Take alternating temperature showers.
- Get out of bed slowly and sit on the side of the bed before standing.

AVOID

- Abrupt changes of posture.
- Sitting or standing still for long periods.
- Activities which promote straining e.g. lifting heavy objects, constipation.

If none of the above has helped, your GP may prescribe:

- Compression stockings.
- Salt tablets.
- Medication to elevate blood pressure.
<table>
<thead>
<tr>
<th>Can Exercise Help Postural Hypotension?</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are some exercises that help circulation and reduce symptoms:</td>
</tr>
<tr>
<td>Move your feet up and down.</td>
</tr>
<tr>
<td>Cross and uncross your legs.</td>
</tr>
</tbody>
</table>

These simple exercises stimulate your circulation. You can do them in bed, or whilst sitting and should do them before you change position or if you have been sitting or lying down for a while.
**APPENDIX 3 – Risk of Falls Care Plan**

<table>
<thead>
<tr>
<th>Nursing Problem/Need</th>
<th>Expected Outcome</th>
<th>Nursing Care Plan</th>
<th>Action taken or N/A where no action necessary</th>
<th>Date</th>
<th>Sign</th>
</tr>
</thead>
</table>
| Patient is at risk of falls | To reduce the risk of Falls within the Health Care setting Whilst promoting a safe environment | • Patients risk of falls highlighted at each handover(SBAR)  
• Use Cannard assessment tool to identify risk.  
• Liaise to MDT in order to identify appropriate management | | | |
| Due to: | | | | | |
| • History of falls prior to admission | | | | | |
| • Record date: | | | | | |
| • Falls since admission | Patient to feel secure/ whilst promoting Independence / Maintain Dignity | | | | |
| • Record Date: | | | | | |
| • Tries to walk alone / unsteady / unsafe | | | | | |
| Medication | | | | | |
| • assess for possible side effects of same  
• Mini Mental evaluation  
• Osteoporosis assessment  
• Possible use of Hip Protectors  
• Mobility aid review | | | | | |
| Eyesight | | | | | |
| • ensure sight is checked wearing glasses if worn/liaise with Medical Team if review needed | | | | | |
| Footwear | | | | | |
| • Asses for proper fit  
• Non slip soles/no trailing laces  
• Discuss with relatives for safe replacement/new slippers  
• Consider the use of slipper socks in bed/at risk of falling at night ensure risk assessment in place | | | | | |
| Lighting | | | | | |
| • Be sensitive to……………………needs respect their lived life  
• Discuss with……………………consider lighting best suited for safety  
• Night light | | | | | |
| Urinalysis | | | | | |
| • Routine ward test to eliminate infection  
• MSSU if positive to nitrates/protein/blood | | | | | |
<table>
<thead>
<tr>
<th>Patients/family informed about falls</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Record Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Inform Medical Team of same
- Take temperature

**Toilet**
- Is patient more at risk when trying to utilising toilet facilities
- Offer regular toilet interventions throughout shift

**Bed and Bedrails**
- Assess/evaluate need for bed rails (NHS Policy)
- Staff to review Bed Rails daily whilst making bed/ ensure correct adjustment/fitting
- Ensure Bed is at lowest optimum level
- Call bell in place
- Ensure safe ergonomic environment

**Lying Standing BP**
- Assess Lying & Standing BP and record/ Record Pulse
- Inform medical Team should deficit manifests
- Advise patient on slow movement from sitting/ lying to standing, consider anti embolism stockings

**Position within Ward**
- Ensure.................is placed within the most appropriate place for their needs
- Close to nurses station/toilet/quiet area of ward/considering the needs of fellow patients also

**Ensure patient/ family participate in plan of care**
- Assess contact details and wishes in event of Fall
- Take time to reassure patient, be sensitive to their needs and respect their lived lives. Whilst promoting independence and Autonomy
# STRATIFY Falls Risk Assessment Tool

<table>
<thead>
<tr>
<th>Questions 2-4</th>
<th>Do you think the patient is</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the patient present to hospital with a fall or has he/she fallen on the ward since admission?</td>
<td>Yes (=1)</td>
</tr>
<tr>
<td>2. Agitated?</td>
<td></td>
</tr>
<tr>
<td>3. Visually impaired to the extent that everyday function is limited?</td>
<td></td>
</tr>
<tr>
<td>4. In need of especially frequent toileting?</td>
<td></td>
</tr>
<tr>
<td>5. Does the patient have a combined transfer and mobility score of 3 or 4?*</td>
<td></td>
</tr>
</tbody>
</table>

**Total score**

<table>
<thead>
<tr>
<th>Review date</th>
<th>Signature</th>
</tr>
</thead>
</table>

* Transfer score: 0=unable  
1=major help needed (1 or 2 people, physical aids)  
2=minor help (verbal or physical)  
3=independent  

Mobility score: 0=immobile  
1=independent with aid of wheelchair  
2=walks with help of 1 person  
3=independent  

**Maximum total score = 5**  
**Total score of 2 or above = high risk of falls**
### APPENDIX 5

#### Guidelines for completing STRATIFY Falls Risk Assessment

<table>
<thead>
<tr>
<th>Question:</th>
<th>Score 1 if the patient was admitted due to a fall, or has fallen on the ward since admission. Score 0 if no to both.</th>
<th>Based on your clinical judgement: Score 1 if yes Score 0 if no</th>
<th>Based on your judgement Score 1 if yes Score 0 if no</th>
<th>Based on your judgement Score 1 if yes Score 0 if no</th>
<th>If transfer score + mobility score equals: 1 or 2, then score 0 3 or 4, then score 1 5 or 6, then score 0</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the patient present to hospital with a fall or has he/she fallen on the ward since admission?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you think the patient is agitated?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you think the patient is visually impaired to the extent that everyday function is limited?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Do you think the patient is in need of especially frequent toileting?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Combined transfer and mobility score of 3 or 4?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transfer score:**

- e.g. moving from bed to chair or commode

<table>
<thead>
<tr>
<th>Score 0=unable e.g. hoisted, or on bed-rest</th>
</tr>
</thead>
<tbody>
<tr>
<td>1=major help needed e.g 1 or 2 people, physically assisting</td>
</tr>
<tr>
<td>2=minor help e.g prompting or supervision</td>
</tr>
<tr>
<td>3=independent – no help or supervision</td>
</tr>
</tbody>
</table>

**Mobility score:**

- i.e. walking/moving around

<table>
<thead>
<tr>
<th>Score 0=immobile i.e. does not move</th>
</tr>
</thead>
<tbody>
<tr>
<td>1=independent with aid of wheelchair</td>
</tr>
<tr>
<td>2=walks with help of 1 person (including supervision) – with or without other aids</td>
</tr>
<tr>
<td>3=independent – with or without aids</td>
</tr>
</tbody>
</table>

**Maximum total score (add questions 1-5) = 5**

**Total score of 2 or above = high risk of falls** – **[highlight within care plan, safety briefing]**, refer to physiotherapy and consider additional preventive measures
## APPENDIX 6

### Rapid Impact Checklist: Summary Sheet

<table>
<thead>
<tr>
<th>Positive Impacts (Note the Groups affected)</th>
<th>Negative Impacts (Note the Groups affected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>Possible issues with managing cultural change for staff and patients i.e. move towards co-production from a ‘dependency model’</td>
</tr>
<tr>
<td>Improved Patient safety through assessment and interventions</td>
<td></td>
</tr>
<tr>
<td>More focus on prevention rather than crisis/incident management</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Information and Evidence Required

### Recommendations

Nil.

From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?

There is no requirement for a full EQIA process as the implementation of this policy should support the inclusion of all staff.